AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: JENAME ARELLANEZ

Date of Birth: 3-3-1978 Social Security Number: 463-43-7709

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual(s) or organization(s) are authorized to make the disclosure:

_____

The type of information to be used or disclosed is as follows from 10 / 12 / 17 to the present:
(check the appropriate boxes and include other information where indicated)

☐ problem list ☐ medication list ☐ list of allergies
☐ immunization records ☐ most recent history ☐ most recent discharge summary
☐ lab results ☐ x-ray and imaging reports ☐ consultation reports from _____
☑ entire record ☐ other: (please describe) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name: **JIM DARNELL, P.C.**
Address: 310 North Mesa, Suite 212, El Paso, Texas 79901

This information for which I'm authorizing disclosure will be used for the following purpose:

☐ my personal records ☐ sharing with other health care providers as needed
☑ other (please describe): Legal/Attorney

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire (insert date or event): TWO YEARS FROM THE DATE HEREOF, UNLESS OTHERWISE REVOKED *(If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed).*

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I AM WILLING THAT A PHOTOSTATIC REPRODUCTION OF THIS FORM SHALL HAVE THE SAME EFFECT AS THE ORIGINAL

_____ 3-9-2021
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____